STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445114	A. BUILDING _____ B. WING _____	11/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRAKEBILL NURSING HOME INC.	5837 LYONS VIEW PIKE KNOXVILLE, TN 37919

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS During annual recertification survey and complaint survey #28927 conducted on November 14-16, 2011, at Brakebill Nursing Home, no deficiencies were cited in relation to the complaint under 42 CFR PART 482.13, Requirements for Long Term Care.	F 000		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement.	F 278		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Michelle Blakelee Wilkerson TITLE: Assistant Administrator (X6) DATE: 11/30/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 278	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on medical record review and interview the facility failed to complete an accurate Minimum Data Set (MDS) assessment to reflect the resident's fall status, for one resident (#20) of thirty-three residents reviewed. The findings included; Resident #20 was admitted to the facility on February 28, 2011, with diagnoses including End Stage Chronic Obstructive Pulmonary Disease, Syncope, and a History of Trans-Ischemic Attacks and Cerebral Vascular Accident. Medical Record review of the MDS dated September 22, 2011, revealed resident #20 was mildly cognitively impaired and required supervision with ambulation and limited staff assistance with transfers. The MDS also indicated the resident had no falls since the previous MDS assessment dated June 29, 2011. Medical record review of a nurse's note dated July 27, 2011, revealed resident #20 had a fall on that date at 1:40 a.m., and was transported to the emergency room for evaluation. The resident returned to the facility at 7:15 a.m., July 27, 2011, with no new treatment orders after the Emergency Room (ER) evaluation revealed no significant injury. Medical record review of a physician's progress note dated August 9, 2011, also noted the July 27, 2011 fall and ER evaluation.	F 278	What corrective action will be accomplished for resident #20 found to have affected by the deficient practice, that facility failed to ensure that resident was properly assessed and documented correctly on MDS for falls. The MDS coordinators were verbally inserviced that they are to assess and capture all falls accurately on all MDS's. How the facility will identify other residents having the potential to be affected by the deficient practice that facility failed to assess and capture falls on MDS. All residents have the potential to be affected. Facility will have the nurse that audits charts check as she reviews charts that falls are documented on MDS. What measures will be put into place to ensure that the deficient practice does not recur. The nurse chart auditor will check bi-annually that falls are captured properly on MDS. How the corrective action will be monitored to ensure that the deficient practice does not recur. The nurse chart auditor will address her findings with MDS nurses bi-annually and will report findings in QI bi-annually times 2, then yearly. QI team consists of Medical Director, DON, ADON, Nurse Chart Auditor, MDS Coordinators, Activity Director, Rehab Manager, Dietary Manager, Medical Records Director, Social Services, Housekeeping Supervisor, Maintenance Supervisor, and Consulting Pharmacist.	12-1-11

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F 278	Continued From page 2 Review of a facility investigation dated July 27, 2011, also indicated the resident had fallen, on that date and was transported to the ER for evaluation. Interview with the MDS Coordinator, on November 16, 2011, at 9:40 a.m., in the MDS office, confirmed the medical record included documentation of a fall that had not been captured on the next MDS assessment dated September 22, 2011. Interview with the Director of Nurses (DON) on November 16, 2011, in the conference room also confirmed the July 27, 2011, fall for resident #20 had not been captured and the MDS assessment was inaccurate.	F 278		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview the facility failed to re-assess bladder continence retraining for one (#8) and failed to accurately assess one (# 22) for bladder	F 315		

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F 315	Continued From page 3 continence training of thirty-three residents reviewed. The findings included: Resident #8 was admitted to the facility on July 15, 2011, with diagnoses including Bi-Polar Disease, Respiratory Failure, and Dysphagia. The resident was re-admitted on October 10, 2011, with diagnoses including Altered Mental Status and Urinary Tract Infection. Medical record review of the Minimum Data Set dated June 2, 2011, revealed the resident had no problem with cognition or memory, and was continent of bladder. Review of the Minimum Data Set dated November 2, 2011, revealed the resident required limited assistance with decision making, had short term memory problems, and was frequently incontinent of bladder. Medical record review revealed the resident was admitted to the hospital on September 19, 2011, with diagnoses of Altered Mental Status and Urinary Tract Infection. The resident was re-admitted to the facility on October 10, 2011, with a Urinary Catheter. Medical record review of a Physician's Order dated October 24, 2011, revealed, "DC (Discontinue)...Catheter". Review of a treatment sheet dated October 24, 2011, revealed the urinary catheter was removed. Review of the medical record revealed no documentation the bladder assessment had been completed after the urinary catheter was removed on October 24, 2011.	F 315	What corrective action will be accomplished for residents #8 and #22 found to have been affected by the deficient practice that facility failed to reassess resident after removal of catheter and that resident #22 was not accurately assessed for bladder continence on admission. All nurses were inserviced on November 16, 17, and 18th, how to accurately assess bowel and bladder on admission. How the facility will identify other residents having the potential to be affected by the deficient practice that facility failed to assess bowel and bladder accurately. All residents have the potential to be affected. The MDS Coordinator will assess resident's bowel and bladder habits quarterly and initiate a new bowel and bladder assessment if needed. What measures that will be put into place to ensure that the deficient practice does not recur. The MDS Coordinators will assess all residents quarterly for changes in bowel and bladder habits and initiate new measures immediately. The CNA will be instructed at time of catheter removal to toilet resident every two hours or on resident request. How the corrective action will be monitored to ensure that the deficient practice will not recur. The MDS Coordinators will assess all residents quarterly for changes in bladder habits and they will report in QI bi-annually times 2 and then yearly. QI team consists of Medical Director, DON, ADON, Nurse Chart Auditor, MDS Coordinators, Activity Director, Rehab Manager, Dietary Manager, Medical Records Director, Social Services, Housekeeping Supervisor and Maintenance Supervisor, and Consulting Pharmacist.	11-18-11

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F 315	Continued From page 4 Observation and interview on November 14, 2011, at 9 a.m., revealed the resident lying in bed, in the resident's room. Interview, at that time, revealed the resident was alert and oriented to time and place. Interview with the resident on November 14, 2011, at 2:00 p.m., in the resident's room, revealed, "Most of the time, I know when I have to go to the bathroom, but I can't hold it sometimes." Interview with a Registered Nurse (#1) on November 14, 2011, at 1:15 p.m., at the nursing station, confirmed the resident had not been re-assessed for bladder continence training after the removal of the urinary catheter on October 24, 2011. Interview with the Minimum Data Set (MDS) Coordinator on November 15, 2011, at 9:30 a.m., in the MDS Office, revealed the facility completes a Urinary Continence Assessment on admission and no further assessments are completed. Resident #22 was admitted to the facility on October 21, 2011, with diagnoses including Dementia, Chronic Kidney Disease, and Congestive Heart Failure. Medical record review of the Minimum Data Set dated October 30, 2011, revealed the resident was always incontinent of bladder. Medical record review of the nurse's note dated October 21, 2011, revealed, "...incont (incontinent) B/B (bowel/bladder) (with) perineeds	F 315		

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F 315	Continued From page 5 met per staff..." Medical record review of the initial urinary continence assessment dated October 21, 2011, revealed, "...Is the resident continent? If yes do not proceed with assessment ..." (marked yes) Interview on November 16, 2011, at 8:55 a.m., with RN (Registered Nurse) #1, at the nursing station, confirmed the urinary continence assessment was inaccurate.	F 315		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of the application instructions for a lap belt, observation, and interview, the facility failed to ensure a safety device was applied correctly for one (#21) resident, failed to provide supervision to prevent an accident for two (#1, #16) residents and failed to ensure a mechanical lift was used to prevent an accident for one (#3) of thirty-three residents reviewed. The findings included: Resident #21 was admitted to the facility on	F 323	What corrective action will be accomplished for resident #21 found to be affected by the deficient practice that facility failed to apply lap belt correctly. The LPN who surveyor reported this to immediately applied lap belt correctly and instructed CNA in proper technique of applying lap belt properly. How the facility will identify other residents having the potential to be affected by the deficient practice of improperly applying lap belts will not recur. All residents have the potential to be affected. All staff will be instructed quarterly with inservice by physical therapist on proper application of restraints. What measures will be put into place to ensure that the deficient practice does not recur. All staff will be inserviced and will demonstrate proper application of all lap belts quarterly by physical therapist.	

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F 323	Continued From page 6 February 1, 2011, with diagnoses including Presenile Dementia, Failure to Thrive, and Osteoporosis. Medical record review of the physician's orders dated October 12, 2011, revealed, "...to be up in regular w/ch (wheelchair) with full lap belt..." Review of the application instructions for a lap belt/padded lap belt revealed, "...Bring the ends of the connecting straps down at a 45-degree angle between the seat and the wheelchair sides...criss-cross the straps behind chair and draw them around the opposite side kick spurs..." Observation on November 15, 2011, at 8:45 a.m., with LPN (Licensed Practical Nurse) #1, in the resident's room, revealed the resident seated in a wheelchair, with a full lap belt in place. Continued observation revealed the right strap of the lap belt between the wheelchair side and seat, and the left strap around the wheelchair side post, straps criss-crossed behind the chair and around the opposite side kick spurs. Interview on November 15, 2011, at 8:45 a.m., with LPN #1, in the resident's room, confirmed the restraint had been applied incorrectly. Resident #1 was admitted to the facility on December 31, 2009, with diagnoses including Cerebrovascular Disease, Diabetes, and Hypertension. Medical record review of the Minimum Data Set dated October 13, 2011, revealed the resident required extensive assistance with two plus	F 323	How the corrective actions will be monitored to ensure that the deficient practice does not recur. Inservices will be documented quarterly and kept on file at nursing home. The DON or ADON will report inservices in QI times 2 bi-annually, then yearly thereafter. QI team consists of Medical Director, DON, ADON, Nurse Chart Auditor, MDS Coordinators, Activity Director, Rehab Manager, Dietary Manager, Medical Records Director, Social Services, Housekeeping Supervisor and Maintenance Supervisor, and Consulting Pharmacist. What corrective action will be accomplished for resident #1 found to be affected by the deficient practice that facility failed to maintain safety with transfers. CNA transferred resident with gait belt and one person assist, resulting in assisted fall. Resident was to have two-person assist with all transfers. The CNA was verbally counseled by the charge nurse at the time of the fall.	12-1-11

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F 323	Continued From page 7 persons physical assistance for transfers. Medical record review of the care plan dated October 2011, revealed, "...assist x 2 with all transfers..." Medical record review of the nurse's note dated October 21, 2011, revealed, "...Resident was being assisted in a transfer from gerichair to bed, lost...balance and was assisted to the floor by a CNA (certified nursing assistant) with gait belt present...no evidence of bruising or injury noted..." Interview on November 15, 2011, at 7:50 a.m., with the Director of Nursing, at the nursing station, confirmed the resident required two person physical assistance for transfers. Resident #3 was re-admitted to the facility on January 13, 2010, with diagnoses including Affective Psychosis, Intervertebral Disc Disorders, and Personal History of Fall. Medical record review of the Minimum Data Set dated August 28, 2011, revealed the resident scored 13 out of 15 on the Brief Interview for Mental Status (cognitively intact), required total assistance of two persons for transfers, and had not had any falls since the prior assessment. Medical record review of a physician's order dated January 13, 2010, revealed "...Sit to Stand (mechanical lift used for transferring residents) for all transfers..." Medical record review of the Care Plan dated	F 323	How the facility will identify other residents having the potential to be affected by the deficient practice that facility failed to maintain resident safety while being transferred. All residents have the potential to be affected. All staff will be inserviced on proper transfers and how to check plan of care/kardex for number of people needed for transfers. What measures will be put into place to ensure that the deficient practice does not recur. All staff will be inserviced quarterly on proper transfers and how to check plan of care/kardex for number of people needed for transfers. How the corrective action will be monitored to ensure that the deficient practice does not recur. Inservices on proper transfers will be kept on file at nursing home. The DON or ADON will report inservices in QI bi-annually times two, then yearly. QI team consists of Medical Director, DON, ADON, Nurse Chart Auditor, MDS Coordinators, Activity Director, Rehab Manager, Dietary Manager, Medical Records Director, Social Services, Housekeeping Supervisor, Maintenance Supervisor, and Consulting Pharmacist.	12-1-11

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F 323	Continued From page 8 June 2011, and updated August 29, 2011, revealed "...all transfers (with) use of sit to stand..." Medical record review of a nursing note dated November 6, 2011, at 8:30 p.m., revealed, "CNA x2 (two Certified Nurse Aides) attempting to transfer resident from w/c (wheelchair) to bed (resident) began sliding shoes slippery. CNA's lowered resident to floor to prevent fall..." Medical record review of a physician's progress note dated November 7, 2011, revealed, "Asked to see pt (patient) S/P (status post) fall during 2 person transfer from chair to bed...no acute injury..." Medical record review of a progress note dated November 7, 2011, revealed, "Falls Team Meetings: on 11-06-11 at 8:30 PM staff transferring res (resident) from w/c to bed. Res slid off chair. Lowered to floor by staff. No apparent injuries noted...last fall was reported on 6/22/11. Staff will be re-educated in use of sit (with) stand transfers..." Interview with the Director of Nursing and review of facility documentation on November 15, 2011, at 9:00 a.m., in the Medical Records office, confirmed the resident's care plan was not followed when two CNAs transferred the resident without use of the sit to stand lift, which resulted in the resident's fall.	F 323	What corrective action will be accomplished for resident #3 found to be affected by the deficient practice that facility failed to maintain safety with transfer. Two CNAs were transferring resident without the use of sit-to-stand lift as ordered and careplanned. The CNAs were verbally counseled at time of fall. How the facility will identify other residents having the potential to be affected by the deficient practice that facility failed to maintain resident's safety while being transferred. All residents have the potential to be affected. All staff will be inserviced on proper transfers quarterly. What measures will be put into place to ensure that deficient practice does not recur. All staff will be inserviced on proper transfers quarterly and demonstrate transferring techniques. How the corrective actions will be monitored to ensur that the deficient practice does not recur. Inservices done quarterly on proper transfer techniques will be kept on file at nursing home. The DON or ADON will report inservices in QI bi-annually times two, then yearly. QI team consists of Medical Director, DON, ADON, Nurse Chart Auditor, MDS Coordinators, Activity Director, Rehab Manager, Dietary Manager, Medical Records Director, Social Services, Housekeeping Supervisor, Maintenance Supervisor, and Consulting Pharmacist.	12-1-11

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F 323	Continued From page 9 Resident #16 was admitted to the facility on October 17, 2007, with diagnoses including Dementia, Chronic Vertigo, Chronic Pain and a history of falls. Medical Record Review of the Fall Risk Assessments dated August 2, 2010, through October 20, 2011 revealed resident #16 with intermittent confusion, the resident was ambulatory with balance disturbances, and the resident takes multiple medications that elevate falls risks. Resident #16 was assessed as high risk for falls. Medical record review of a Minimum Data Set (MDS) assessment dated October 20, 2011, revealed resident #16 required extensive assistance with transfers and locomotion. Medical record review of a care plan dated October 21, 2011, revealed the resident required the assistance of two staff for all transfers. Continued care plan review of an entry date April 8, 2011, revealed the resident required direct supervision with toileting. Review of a facility documentation dated June 7, 2011, revealed resident #16 fell, when a CNA transferred the resident to the bathroom alone, released the resident's lap belt (safety device), and " ...was called away before helping the resident to the toilet ...Res (resident) has dementia and no safety awareness ..." The resident attempted an unassisted/unsupervised transfer to the toilet and fell. Interview with RN #3, Green Hall (300 hall)	F 323	What corrective action will be accomplished for resident #16 found to be affected by the deficient practice that facility failed to maintain resident safety while being toileted. Resident left unattended and required supervision of toileting needs. Resident sent to emergency room for evaluation. The CNA was terminated. How the facility will identify other residents having the potential to be affected by the deficient practice that facility failed to maintain safety for resident during toileting. All residents have the potential to be affected. All staff will be inserviced on supervising any resident that requires use of restrictive device when out of bed. CNA's employment may result in terminiation if they fail to comply with proper supervision. What measures will be put into place to ensure that the deficient practice does not recur. All staff will be inserviced quarterly on providing proper supervision for all residents using restrictive and/or safety devices when being toileted. The staff will be told if they fail to comply with proper supervision, termination of employment may result.	12-1-11

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F 323	Continued From page 10 Charge Nurse, on November 15, 2011, at 9:45 a.m., at the Green Hall Nurses Station, confirmed the resident had not been supervised while toileting as care planned and suffered a fall, requiring an emergency room evaluation to rule out significant injury. Interview with the Director of Nursing (DON) on November 16, 2011, at 7:47 a.m., in the conference room confirmed the June 7, 2011, fall occurred while the resident was unsupervised.	F 323	How the corrective actions will be monitored to ensure that the deficient practice does not recur. Inservices will be kept on file at nursing home and terminations will be kept on file . The DON and ADON will address inservices and terminations will be reported in QI bi-annually time two, then yearly. QI team consists of Medical Director, DON, ADON, Nurse Chart Auditor, MDS Coordinators, Activity Director, Rehab Manager, Dietary Manager, Medical Records Director, Social Services, Housekeeping Supervisor and Maintenance Supervisor, and Consulting Pharmacist.	12-1-11
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if	F 441	What corrective action that will be accomplished for the deficient practice that facility failed to maintain proper infection control, evidenced by CNA #2 improperly filling ice pitchers. Surveyor reported this to LPN #1 and she immediately demonstrated proper technique in filling water pitchers and hand sanitizing to comply with infection control. How the facility will identify other residents that have the potential to be affected by the deficient practice of improper infection control. All residents have the potential to be affected. All CNAs will be inserviced on proper techniques of passing ice/filling water pitchers and proper hand sanitizing. What measures will be put into place to ensure the deficient practice does not recur. The staff will be inserviced quarterly on proper infection control when filling water pitchers and proper handwashing and hand sanitizing.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445114	A. BUILDING _____ B. WING _____	11/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRAKEBILL NURSING HOME INC.	5837 LYONS VIEW PIKE KNOXVILLE, TN 37919

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 11 direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain infection control during ice pass on the Green hallway for three residents. The findings included: Observation on November 15, 2011, outside the resident's rooms on the green hallway, at 8:25 a.m., revealed Certified Nurse Assistant (CNA) #2, filling ice water pitchers for three residents outside of the resident's rooms. Continued observation revealed the CNA went into each resident's room (two residents per room), brought the used water pitchers outside the resident's rooms, used a scoop that touched the inside of the water pitcher, held the pitchers over the top of the ice chest and filled the pitchers with ice (pitchers had already been used by the residents) without cleaning the scoop between resident's. Further observation revealed the CNA returned the water pitchers back into each resident's room and exited without sanitizing the hands.	F 441	How the corrective actions will be monitored to ensure the deficient practice will not recur. Staff will be inserviced quarterly on infection control and proper handwashing and sanitizing when filling water pitchers quarterly. Will be addressed in QI by DON or ADON bi-annually times 2, then yearly. QI team consists of Medical Director, DON, ADON, Nurse Chart Auditor, MDS Coordinators, Activity Director, Rehab Manager, Dietary Manager, Medical Records Director, Social Services, Housekeeping Supervisor and Maintenance Supervisor, and Consulting Pharmacist.	12-1-11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 441	Continued From page 12 Interview with CNA # 2, on November 15, 2011, at 8:27 a.m., in the hallway, confirmed the pitchers had been used by the residents, the used pitchers were filled with ice over the top of the ice chest and the scoop was contaminated when placed inside with water pitchers. Further interview confirmed the CNA had not sanitized the hands between residents. Observation and interview with Licensed Practical Nurse (LPN) #1, the green unit charge nurse, on November 15, 2011, at 8:30 a.m., in the hallway, confirmed the used ice pitchers were filled directly over the ice chest, the scoop was contaminated when placing ice into the resident's water pitcher and the CNA did not sanitize the hands between resident's rooms. Further interview confirmed the CNA failed to follow standard infection control practice.	F 441		